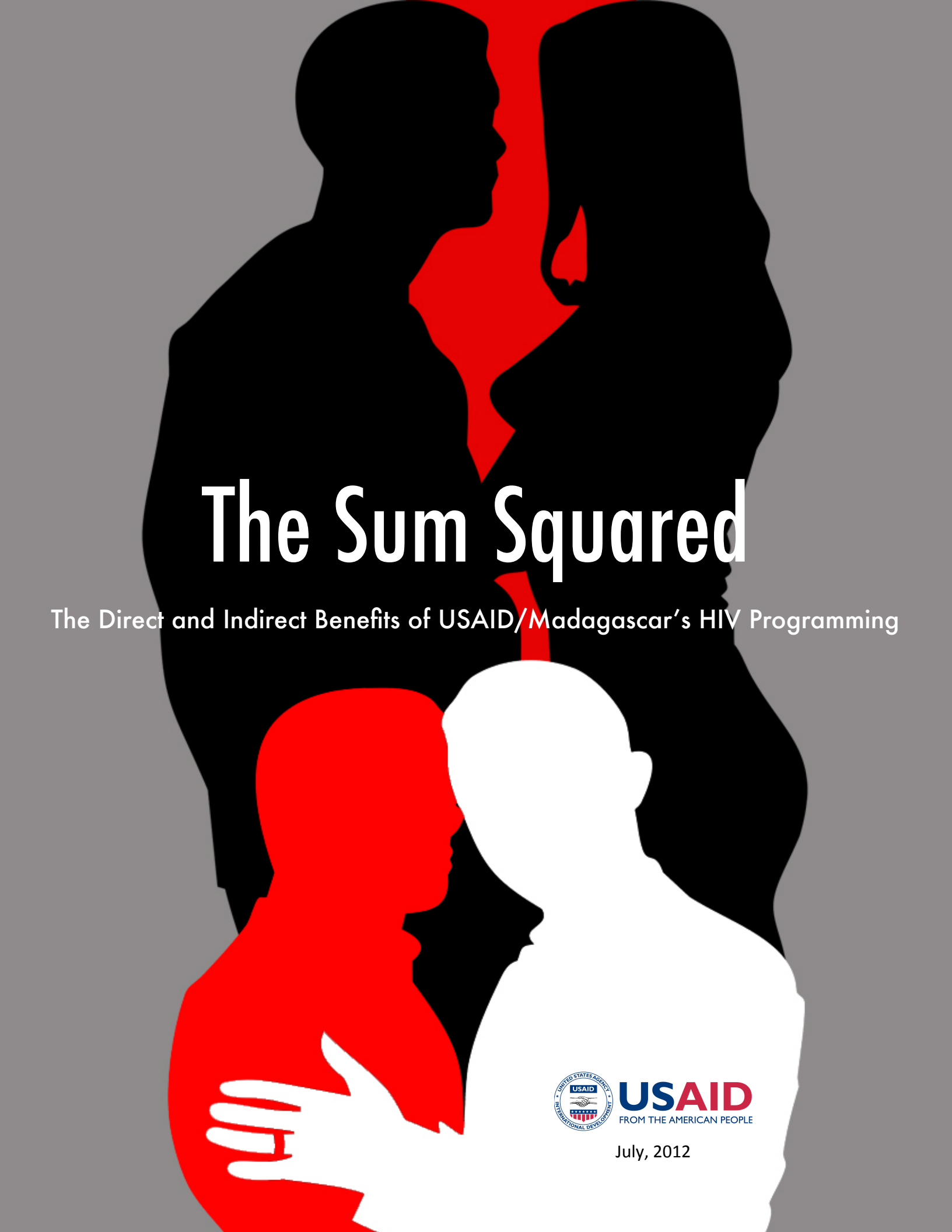


The Sum Squared

The Direct and Indirect Benefits of USAID/Madagascar's HIV Programming

USAID
FROM THE AMERICAN PEOPLE

July, 2012

Index

In the Dark of Night

The sun has set in Antananarivo and the neighborhoods are transforming. Mothers take their children home. Shopkeepers close up their wares. A few tourists stroll around, blind to the scenes taking place in the shadows. In the park just across from the Presidential Palace, peer educators in green long-sleeve polo shirts quietly approach park benches and their occupants. They have something to say.

Like in much of Africa, homosexuality is taboo in Madagascar, and thus it is hidden. Men who have sex with men (MSM) keep their affairs secret from almost everyone. Occasional websites and chat rooms may open up a dialogue, but few people will admit to being MSM.

The most visible population of MSM are those who sell sex after dark in city parks and other quiet locales. Since the hourly hotels refuse to rent a room to them, the men have sex behind bushes or fences, with no protection from occasional police harassment[1]. These encounters are transactional in nature. One man will wait quietly in the park, looking for someone to approach him. A price is negotiated. Condom usage is discussed with a verdict often depending on the price. And then a location is found. Afterwards, the sex worker returns to his quiet waiting game, looking for another client. This can happen many times a night.

The peer educators in the green polos talk with the men sitting on the park bench. These are usually the sex workers, killing time between clients. The peer educators – who know the work and sometimes ply the trade themselves – pass out leaflets, free condoms, and sometimes packets of lube and vouchers. The vouchers provide access to quality health care clinics where the men can get tested and treated for Sexually Transmitted Infections (STIs) and tested for HIV. The nearest clinic is just across the street.

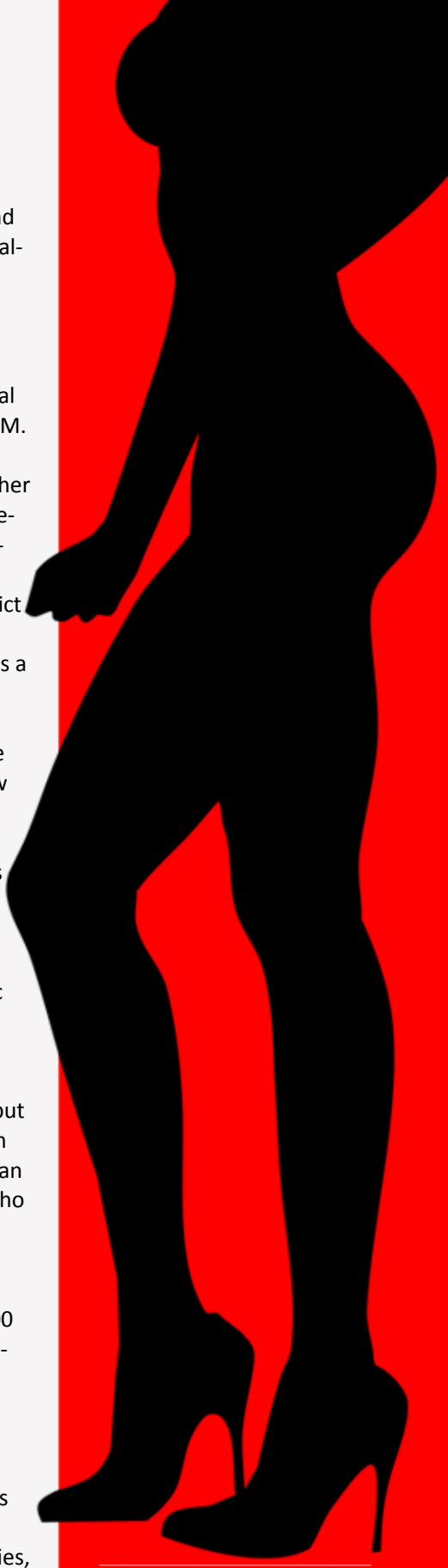
Finding a good doctor is important because the effects of high-volume gay sex work are sometimes difficult to hide. Syphilis and other sexually transmitted diseases are endemic here and there are few ways to explain away anal sores to an unfriendly physician. The medical profession is not immune from stigmatizing.

The men who come to the park looking for sex are either not Malagasy or are Malagasy but don't identify as gay. Many are looking for quick sex and then a return to their lives, often with their wives and children. To researchers, these people are lost to follow-up. They can neither be found later nor will they discuss their lives and behaviors. Instead, the men who work the park and charge for their services – charge more than female sex workers – are the researcher's best, and often only, link to the lives of MSM in Madagascar.

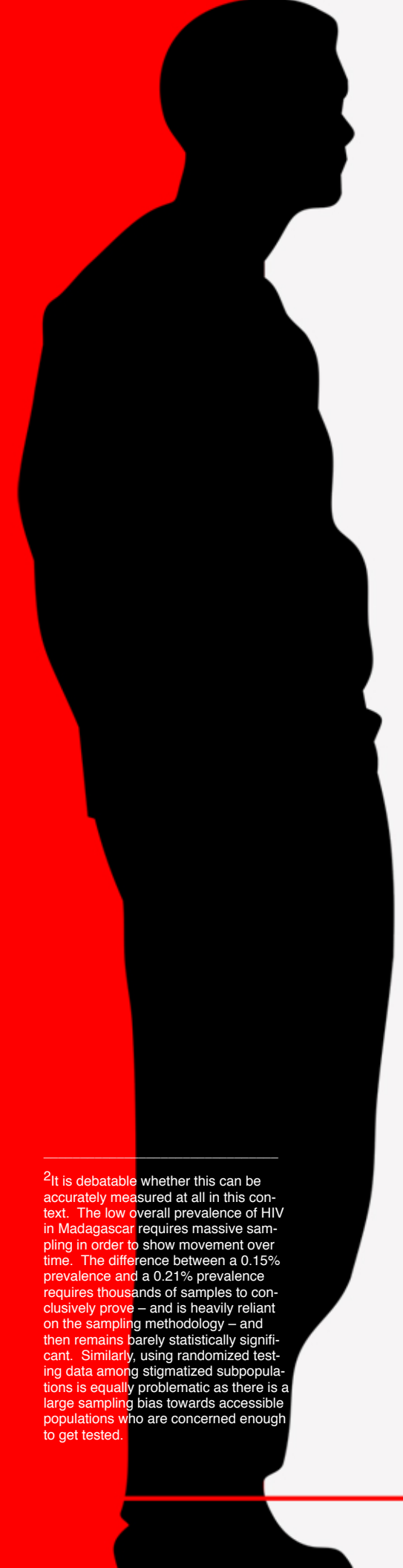
Malagasy MSM, many of whom sell sex, test positive for HIV at a rate of 14.7%, nearly 100 times higher than pregnant women seeking prenatal care. They have the highest concentration of HIV cases on the island nation, however there are few good estimates of their numbers. There is even less data about their male clients.

In Madagascar, MSM have seen some progress in the last few years. MSM and transvestites who sell sex have organized themselves into associations, often teaming their efforts with female sex workers to demand rights, seek services, and reduce stigma. However, many MSM still feel too stigmatized to join. They fear exposure of their nocturnal activities, and some – maybe many – do not even identify as gay.

Malagasy peer educators come from this sub-culture. They dress as men – for the most part – and they link together the shadowed world of the MSM sex worker with the efforts to fight HIV/AIDS.



[1]Technically, homosexuality is legal in Madagascar, although each party must be over 21 years of age, whereas heterosexual commercial sex workers must register with authorities to show that they are over 18.



The Bigger Fight

Madagascar suffers from high STI rates and fecundity with only about one condom distributed per year per male. It can be crudely said that the Malagasy are not having less sex or using more condoms than those on the other side of the Mozambique straights. However, the island nation benefits from a natural barrier against vehicular traffic from mainland Africa and near universal male circumcision. These natural dynamics help account for the low HIV prevalence among the general population.

USAID's efforts to reduce the spread of HIV in Madagascar are low-dollar by regional standards. The U.S. government spends a mere two million dollars a year on HIV programming in Madagascar, and that number is slated to be halved and then eliminated in two years' time. The funding is routed through two Non Governmental Organizations (NGOs) who in turn work through local groups and associations. With these limited funds, USAID focuses its efforts across several risk groups, including MSM, female commercial sex workers (FSWs), the clients of female commercial sex workers, and youth, collectively known as most at-risk populations (MARPs).

With the exception of youth, it is very difficult to know the size of these risk group populations. In fact, just defining them is a challenge.

Female commercial or transactional sex, for example, ranges from women waiting at bars or nightclubs looking for a John; to a young girl who is offered to a visiting dignitary for sex; to a university student waiting for a rich tourist to call her cellphone; to a homeless girl selling sex to feed her siblings. The price of a single sexual encounter can vary from over $100 USD to barely 25 cents USD.

Men who have sex with men are similarly varied. Some dress in women's clothes and sell sex in parks and street corners. Others sneak away from their heteronormative lives to buy sex in the park. It is not clear how many men seek out non-financially-linked sex, either through the Internet or a clandestine bar scene.

Different partners have different preferences, as do the male sex workers (MSWs) who work the park. Some identify as "dogs" or "tops" and prefer to be the penetrating partners. Others will only be "nats" or "bottoms," choosing instead to be penetrated. Some have no preference.

For reasons of access and efficacy, USAID's efforts focus on the most visible, highest risk groups - those at the far ends of the spectra. However, this approach ignores many who are also at-risk.

USAID uses several tools to reach out to these high-risk groups, including training peer educators, capacity development with local associations and networks, and strengthening the supply of and demand for health care services to deal with HIV and sexual health issues. Each of these approaches has clear and direct outputs that relate to HIV prevention, care and treatment. Each also has a wider impact that cannot be measured solely in HIV-specific outcomes[2]. The effects of these programs cross health sectors and diseases and jut decisively into the areas of access to health care, human rights, and reproductive health. In each of these areas, USAID's HIV interventions have clearly demonstrated progress.

[2]It is debatable whether this can be accurately measured at all in this context. The low overall prevalence of HIV in Madagascar requires massive sampling in order to show movement over time. The difference between a 0.15% prevalence and a 0.21% prevalence requires thousands of samples to conclusively prove – and is heavily reliant on the sampling methodology – and then remains barely statistically significant. Similarly, using randomized testing data among stigmatized subpopulations is equally problematic as there is a large sampling bias towards accessible populations who are concerned enough to get tested.

Equal Rights

For many years, HIV in Madagascar was almost mythical. Everyone assumed that HIV had to exist in Madagascar. The island was a short flight from a dozen countries with epidemic and hyper-epidemic situations. STI rates and fertility were high. Condom use was rare and sex work was clearly evident. But the data was not present. In fact, ante-natal clinics would test hundreds and sometimes thousands of clients without showing a single HIV-positive mother-to-be. Was USAID wasting its money looking for HIV where there was none?

One day, a USAID implementer noticed that there was an overlap between the people attending the meetings of a transgender association and those attending a Persons Living with HIV and AIDS (PLWHA) group. A connection was made. The implementing partner dove into the world of Madagascar's transgender population and, by connection, the Malagasy men who have sex with men[3].

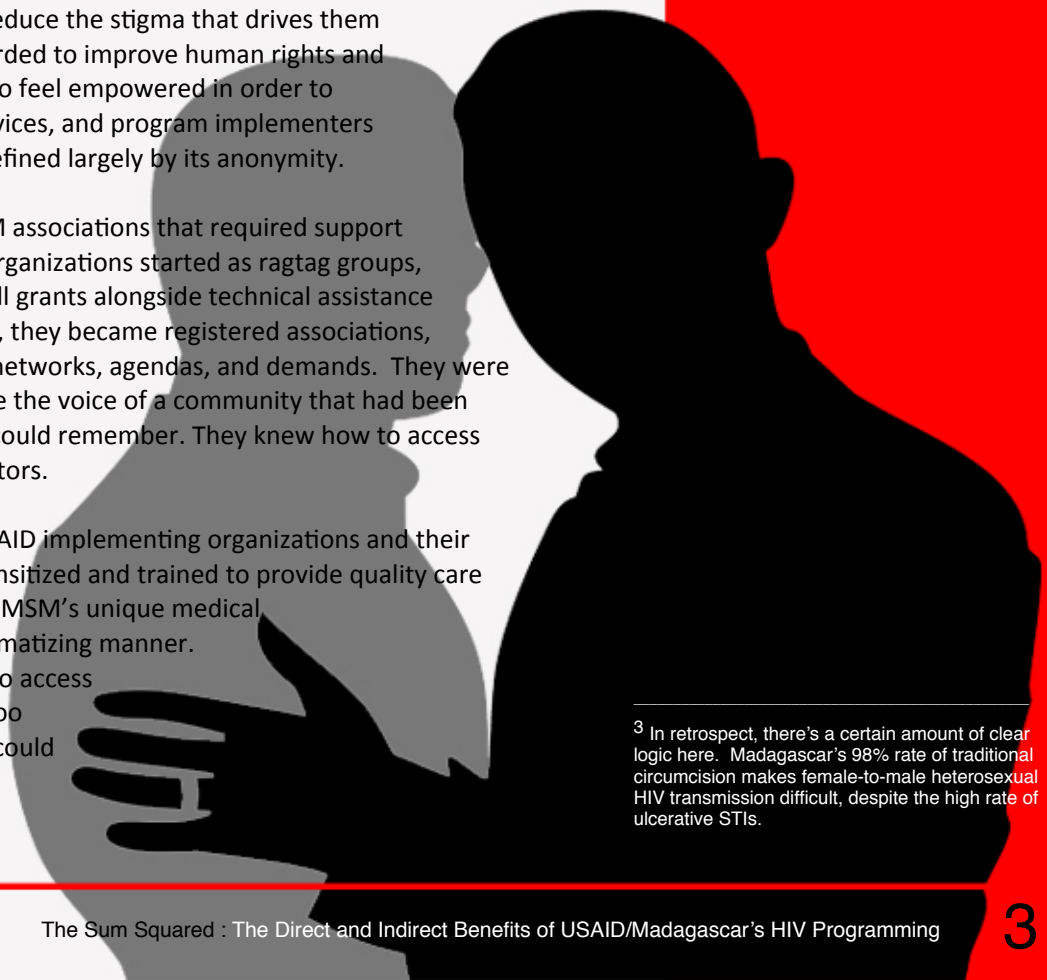
Malagasy MSM are defined largely by their extreme examples. Self-identifying MSM are often those who sell sex and sometimes those who cross-dress. These behaviors are entirely taboo in Malagasy culture and result in clandestine, hidden populations. These hidden populations are largely powerless.

They face police harassment. Often, they are thrown out of their homes and face violence on their own "like dogs on the street." In one report, an MSM association member was attacked and raped with an iron bar. In another case, an MSM was decapitated and his house burnt down. Even less extreme examples show a Malagasy society intolerant of differences. Sometimes even health centers refused to treat MARPs or would insist that they wait until all other patients had been seen.

USAID sought to empower MSM and reduce the stigma that drives them underground. This strategy was forwarded to improve human rights and program effectiveness. MSM needed to feel empowered in order to self-identify and not fear accessing services, and program implementers needed to reach out to a population defined largely by its anonymity.

The solution was to work through MSM associations that required support in order to assert themselves. These organizations started as ragtag groups, disconnected and unofficial. With small grants alongside technical assistance to develop capacity provided by USAID, they became registered associations, with membership lists, active support networks, agendas, and demands. They were trained in their rights, and they became the voice of a community that had been disenfranchised for as long as anyone could remember. They knew how to access services and could serve as peer educators.

The men themselves began to trust USAID implementing organizations and their brands. TOP Réseau clinicians were sensitized and trained to provide quality care for MSM. The clinicians learned about MSM's unique medical needs and how to behave in a non-stigmatizing manner. On the patient side, MSM were eager to access non-stigmatizing medical services, all too aware that certain medical conditions could instantly identify their behaviors.

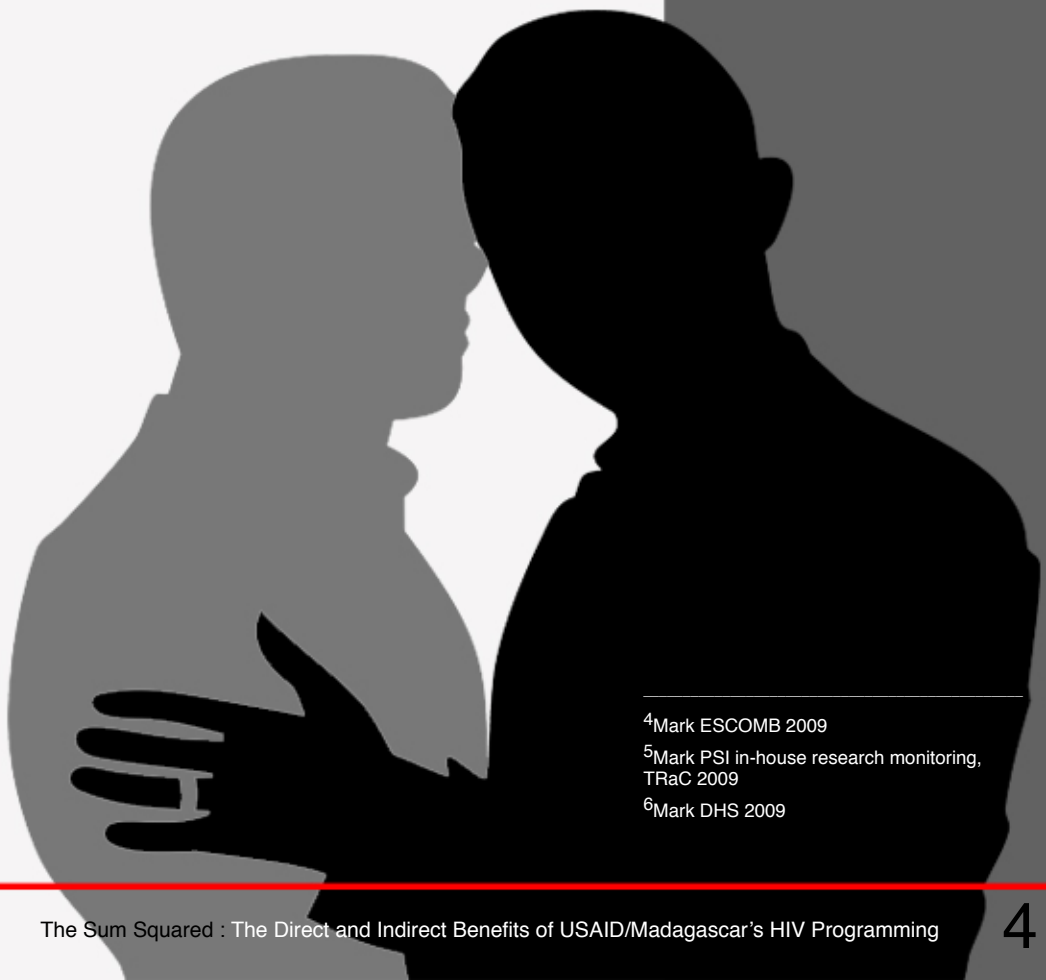


[3] In retrospect, there's a certain amount of clear logic here. Madagascar's 98% rate of traditional circumcision makes female-to-male heterosexual HIV transmission difficult, despite the high rate of ulcerative STIs.

The MSM associations began to demand their human rights, too. They approached community leaders and those in power and demanded that discrimination stop. Community members who refused to rent rooms to presumed MSM were educated in Malagasy law. Another USAID project began training MSM to request services and become active participants in their communities.

These efforts seem to be having other positive effects. Due to large-scale distribution through USAID's social marketing program, about 118 million condoms were made available in Madagascar between 1996 and 2011. Consequentially, condom use has increased to 74% among MSM, 63% among FSW clients, and 86% among FSW. However, condom use among youth remains low: 8% among male youth and 6% among female youth.

Above all, MSM are now accessing health care at higher rates, getting tested for HIV and getting treated for STIs more often. They now dare to think of a life beyond selling sex, where computer training or other vocational skills can provide better lives.



[4]Mark ESCOMB 2009

[5]Mark PSI in-house research monitoring, TRaC 2009

[6]Mark DHS 2009

The Consequences of Economic Collapse

Saraha said it didn't used to be this way. She was walking around downtown Antananarivo a few hours after the sun had set, on the outskirts of a mid-range hotel with hidden hourly hotels next door. The girls were lined up alone or in small groups; some looked barely thirteen years old, most looked consumed with hunger. These were not sex workers by anything except desperation. The economic situation had been bad before but, Saraha explained, *la crise politique* had made things worse. She said that some of these girls were a result.

As she walked further, another girl wearing pants and a dark blue poncho said hello. The poncho and its logo, Felana, which means flower in Malagasy, are the symbols of one of Madagascar's only assistance to these exploited girls. Its wearer, Volona, is a peer educator. She earns about a dollar an hour distributing condoms and leaflets, and talking with the young girls about their sexual health. One girl, who looks about 14, said that she is pregnant.

Street-based female commercial sex workers in Madagascar did not come to their work willingly. Many are from poor families and have few other options following the economic collapse. They are set apart from their communities, both by poverty and stigma. Neighbors talk of "cleaning" their neighborhoods of sex workers.

In addition to showing prodigious rates of STIs, female CSWs in Madagascar also become infected with HIV at 10 times the rate of the general population. Despite this, some doctors– although not TOP Réseau providers – refuse to treat them, either due to their own stigma or the fear that their clinics will become stigmatized as havens for CSWs.

USAID's implementing partners have trained over 500 peer educators targeting youth, MSM, FSWs and their clients. In addition to new skills, each receives a basic set of tools. In her poncho, Volona, who herself sells sex on other nights of the week, has a backpack full of help. She carries and distributes some of the 10 million condoms that USAID is providing to Madagascar this year. She carries information packets on STIs and safe sex. And she carries vouchers that provide subsidized medical care at TOP Réseau clinics.

Looking friendly and sociable, Volona talks with the girls about negotiating condom use with their clients, who will often pay a premium for unsafe sex. In 2010 alone, USAID-financed programs reached over 60,000 high-risk persons with information and condoms, most of them sex workers and their clients.

What is shocking on a night out is the way that sex workers outnumber patrons at many bars or cafes. This over-supply reduces each CSW's negotiating power. One girl may insist on using a condom with a client but her friend at the next barstool may not. That said, years of effort have increased CSW condom usage with paid clients up to 86%, although usage drops to about 50% when these same women have sex with their boyfriends.

Under Malagasy law, female commercial sex workers are required to be at least eighteen years old and to register with the authorities. Many CSWs seem to not meet the age requirement. Age does not seem to be an issue for most clients, nor for the STIs that run rampant on the island.

Mainstreaming Care

The clinic looked more like a beach bungalow than a health care site. Sea breezes cut through open windows twenty-four hours a day, keeping pace with the clinic's hours. Three doctors and three nurses kept watch over the local population, with a long-built trust for treating MARPs clients.

The TOP Réseau clinic offers a wide range of services, including testing and treatment of STIs, testing and referrals for HIV, prenatal care, family planning, CSW check-ups and general medicine. There is a pharmacy downstairs that can meet many needs – especially pills to treat embarrassing ailments. The staff knows many of the town's peer-educators who bring in their friends and make a direct connection between high-risk populations and primary health care.

The problem with reaching MARPs groups was not simply limited to behavior but to a lack of comfort with the health care system in Madagascar. The country has 3,000 doctors but health care access, especially among marginalized populations, has been weak. Outpatient clinics closed on weekends and lacked essential medicines.

USAID's efforts to improve health care for MARPs have relied on enhancing the accessibility and quality of services among private provider networks. Clinics needed training, standardization and the will to work with MARPs. USAID also needed to gain a better understanding of the epidemic, which required increasing testing and treatment.

The TOP Réseau private clinic program sought to change the status quo. Clinicians were trained to take time with and listen to their clients, and often received multiple trainings over a period of years. Health care clinics had minimum quality standards that they were obliged to respect. Essential products and treatments were kept in stock as a requirement. The TOP Réseau brand came to be seen as a mark of quality.

Clinics were also directly linked to other USAID-sponsored initiatives. Peer educators pass out vouchers to encourage clients to come for low-priced counseling and STI treatments. Often, they accompany patients on their first visit to the clinics – after that, the clients come on their own. Branded products are on hand. Some peer educators, particularly those working with youth, even hold their group outreach sessions in the TOP Réseau health clinics.

At the same time, the clinics' proprietors saw value in building their own brands. TOP Réseau is a social franchise, so each clinic is independently owned and operated but must conform to high-level minimum standards. Each clinic operator keeps their own profits and

thus benefits from a constant influx of clients, even if half of the clients are MARPs. TOP Réseau, with 193 private clinics and 170 doctors, has become a well-known brand for health care services in Madagascar. Due to the broad range of services, a patient does not feel stigmatized walking in – the neighbors do not know if she needs a shot to prevent pregnancy or needs to treat an STI. This may be one reason why over 185,000 people have gotten STIs treated at TOP Réseau clinics.

The bungalow clinic has been a member of TOP Réseau for five years and has seen dramatic changes. It has new and better equipment. Its staff members are better trained. It has seen a big increase in clients – averaging about 600 per month – half of whom have vouchers or are accompanied by a peer educator. Without USAID's support, these people would likely never have received proper services. At best, they might have bought an STI treatment kit quietly in a pharmacy, treated themselves or asked a friend to inject them. Now getting health care from a qualified provider is normal.

Catalytic Effects

USAID/Madagascar's HIV and health programs are insufficient to meet the growing demand for services. Madagascar suffers from low access to primary health care, high rates of STIs, and high birth rates. It also has high HIV prevalence among MSM and other high risk groups, including and sex workers.

Through its partners, USAID has focused on working directly with the highest risk populations, however the effects of these programs are often felt beyond these highest risk groups. Among other things, USAID's HIV programs are directly responsible for providing funding for male condoms for HIV prevention, all the female condoms in Madagascar, socially marketed STI kits, grants to MARPs associations and 193 TOP Réseau clinics. Without this funding, these critical interventions could vanish and, with them, much of the effectiveness of the overall reproductive health program.

The effects of USAID's HIV human rights activities, although more difficult to measure, are perhaps even greater. Groups that once stood invisible to society, except as targets for ill-defined blame, are now asserting themselves. They have formed into associations, registered themselves, and have begun to actively advocate for their rights. They are using the law to reduce discrimination and to increase openness to address stigma. And by becoming peer educators and advocating for treatment, they are supporting their own to achieve better health outcomes.

The integration of services at private clinics has increased access to critical services for vulnerable groups. Madagascar's TOP Réseau clinics and branded health commodities reduce the stigma of going to an HIV or STI clinic and have clearly increased usage. Sales of branded condoms and STI kits have more than doubled since they were introduced in 2000 and 2002, respectively. The female condom has been introduced and purchased 190,000 times.

USAID's outreach work has created a vital bridge between the formal health sector and hidden communities. Youth peer educators have introduced their peers to sensitive subjects such as condoms, contraception, and STIs. MARPs peer educators serve as a first line of defense against the HIV epidemic, STIs and ignorance. These groups form vital linkages to the highest risk HIV populations in Madagascar.

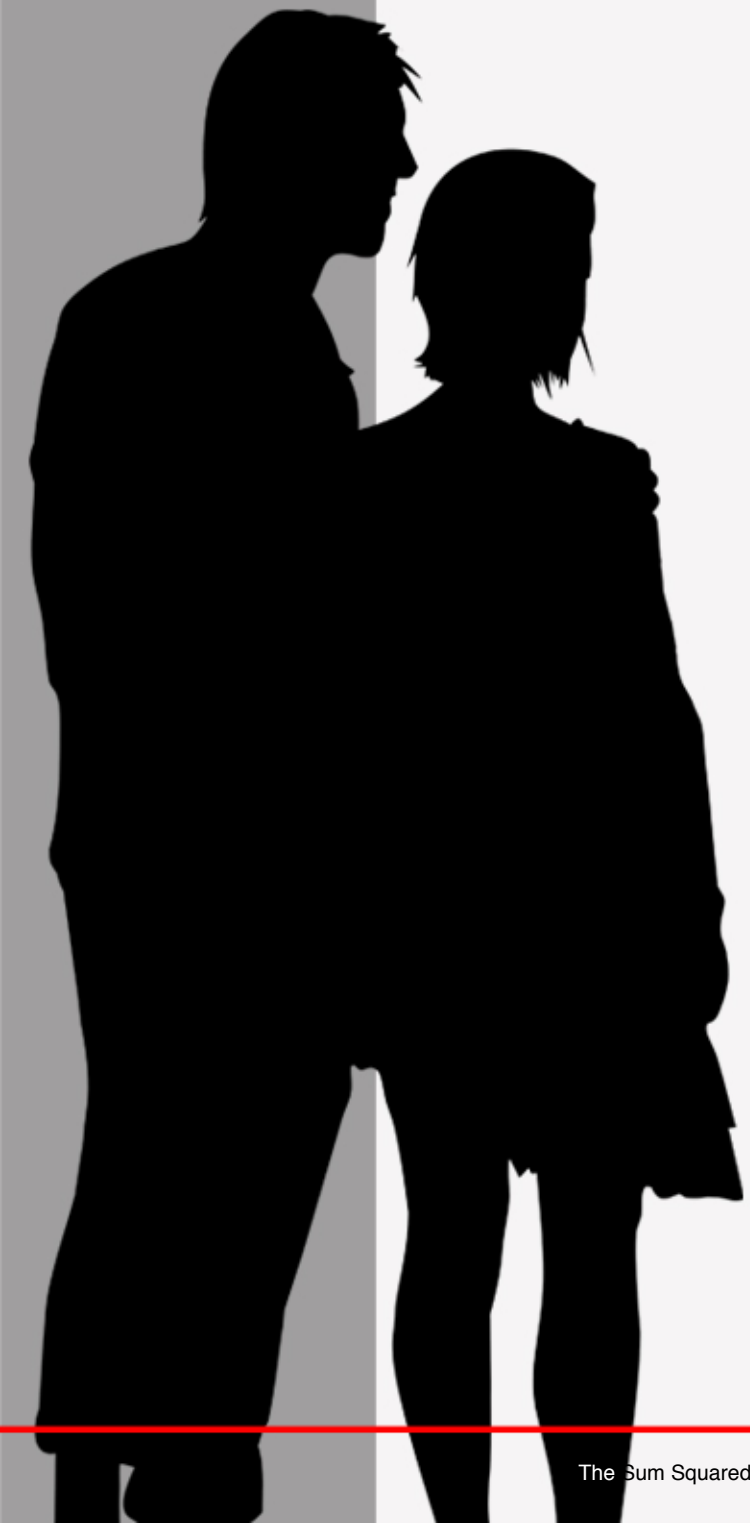
Although founded on the principles and best practices of HIV prevention, each of these achievements transcends the strict limits of HIV programming.

USAID's HIV programs have not accomplished all of this on their own, or entirely with HIV-specific funding. Additional health programming from USAID and support from the Global Fund and World Bank have played a major role, as has support

from the national government. However, USAID's HIV funds have directly financed several critical and irreplaceable interventions and played a catalytic role in supporting other vital programs, particularly those supported by the Global Fund.

USAID also contributed to the realization of an extremely progressive 2005 law entitled "On the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV."

Without this support, it is not clear how or whether these programs could continue and whether the integrated services constructed around them could stand. It is therefore vital for this funding to move forward.



Remaining Challenges

The challenges for USAID/Madagascar will remain myriad whether or not HIV funding continues or is zeroed out. Madagascar's concentrated HIV epidemic makes mass media or wide-scale interventions dramatically less efficient. Supporting peer-to-peer interventions is far more effective, but is also more costly and time-consuming.

In addition, USAID's MARPs efforts have largely focused on the extremes within their subpopulations. Very little is known about Malagasy men who have sex with men, but not for money, for instance, or about Malagasy female high-end commercial sex workers. Each of these groups may comprise high prevalence populations and be largely invisible to researchers.

Finally, Madagascar's health problems – even its sexual health problems – are not remotely limited to HIV. High levels of male circumcision and geographic isolation may have reduced the spread of HIV among the general population, but sexually transmitted infections, high birth rates and low access to health care provide evidence that far more work remains to be done.

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